Confidential Sexually Transmitted Disease (STD)/HIV Report Form
State of Alaska, Section of Epidemiology

Health care providers may use this form to make STD/HIV reports. Please use the Infectious Disease Report Form to report other infectious diseases. Forms may be found at http://dhss.alaska.gov/dph/Epi/Pages/pubs/conditions/crforms.aspx.

Patient Information

Last Name _____ **First Name**_____ **MI** _____

Date of birth ____/____/_____ (mm/dd/yyyy) **Sex:** ☐ Female ☐ Male ☐ Transgender **Pregnant:** ☐ No ☐ Yes; # of weeks _____ ☐ Unknown **Gender of Sex Partners:** ☐ Male ☐ Female ☐ Unknown *(check all that apply)*

Race: ☐ White ☐ Black ☐ Alaska Native/American Indian ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Unknown ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Physical Address _____ **PO Box** _____

City _____ **State**_____ **Zip Code** _____

Phones (home) _____ **(cell)** _____ **(work)** _____

Disease Information

☐ **CHLAMYDIA** ☐ **GONORRHEA** ☐ **SYPHILIS** ☐ **HIV**

Complications: ☐ Pelvic Inflammatory Disease (PID) ☐ Epididymitis ☐ Congenital infection ☐ Disseminated Gonococcal Infection (DGI) ☐ Conjunctivitis ☐ Other _____

Was the diagnosis laboratory confirmed? ☐ Yes ☐ No **Specimen collection date:** ____/____/_____

Type of Specimen: ☐ Urine ☐ Vaginal swab ☐ Urethral/Cervical swab ☐ Pharyngeal swab ☐ Rectal swab ☐ Serum RPR ☐ Serum FTA ☐ Rapid HIV __ oral __ serum ☐ HIV P24 Antigen Screen ☐ HIV EIA ☐ HIV EIA Ag/Ab Combo ☐ HIV Multispot Type 1 Positive ☐ HIV Multispot Type 2 Positive ☐ HIV Western blot ☐ Other: _____

Name of Medical Facility _____ **Phone** _____

Attending health care provider _____ **Laboratory Name (***if known)* _____

Treatment Information (Chlamydia, Gonorrhea and Syphilis Only)

Was treatment prescribed? ☐ Yes ☐ No Date ____/____/_____ Pharmacy *(if known)* _____

Medication:
- ☐ Azithromycin (Zithromax) _____1 gm ____ 2 gm ..... Directly Observed Therapy? ☐ Yes ☐ No
- ☐ Cefixime (Suprax) 400 mg PO ..... Directly Observed Therapy? ☐ Yes ☐ No
- ☐ Rocephin (Ceftriaxone) IM ____250 mg ____Other _____ (mg/g)
- ☐ Doxycycline PO BID ____7 days ____10 days ____14 days
- ☐ Benzathine Penicillin G 2.4 mu IM ____ 1 dose ____ 3 doses

Other Medication: _____ Dosage: _____ # Days: _____

Other Medication: _____ Dosage: _____ # Days: _____

Was EPT *(Expedited Partner Therapy)* provided for sexual partner(s)? ☐ No ☐ Yes # Doses _____

Reported by: _____ **Date Reported:** ____/____/_____

Fax reports to (907) 561-4239 – please verify fax has been transmitted.

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